

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15G389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/22/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>DEVELOPMENTAL SERVICE ALTERNATIVES INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>823 ALHAMBRA ANDERSON, IN 46011</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p>INITIAL COMMENTS</p> <p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey Dates: April 20, 21 and 22, 2015.</p> <p>Facility number: 000903 Provider number: 15G389 AIM number: 100244370</p> <p>Developmental Service Alternatives Inc. was found to be in compliance with 42 CFR, part 483, subpart I and 460 IAC 9 in regard to the recertification and state licensure survey.</p>	W 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.